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33 Psychiatric Treatment Facilities

The policy provisions for psychiatric hospitals and residential treatment facilities (RTFs) may be found in Chapter 41 of the Medicaid Administrative Code. The complete administrative code is found on the Medicaid website: www.medicaid.state.al.us.

Psychiatric services for recipients under age 21 are covered services when provided under the following conditions:

- Under the direction of a physician
- By a psychiatric hospital enrolled as a Medicaid provider **OR**

  By a psychiatric residential treatment facility (RTF) which is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation of Services for Families and Children (COA), or by another accrediting organization with comparable standards that is recognized by the State;
- Before the recipient reaches age 21
- If the recipient was receiving services immediately before he/she reached age 21, before the earlier of the following dates:
  - The date the recipient no longer requires the services
  - The date the recipient reaches age 22
  - The expiration of covered days
    - To a recipient admitted to and remaining in the facility for the course of the hospitalization
    - As certified in writing to be necessary in the setting in which it will be provided in accordance with 42 CFR 441.152.

Psychiatric hospitals and RTFs shall comply with all applicable regulations regarding the use of restraint and seclusion as cited in 42 CFR, Part 441, Subpart D, and 42 CFR, Part 483, Subpart G.

Inpatient and residential psychiatric services are unlimited if they are medically necessary and the admission and the continued stay reviews meet the approved psychiatric criteria. These days do not count against the recipient's inpatient day limitation for care provided in an acute care hospital.

Referrals from a recipient's Patient 1st Primary Medical Provider (PMP) are not required for admissions to psychiatric hospitals or RTFs.

However, hospitals and RTFs should notify the recipient's PMP of the admission within 72 hours by faxing a copy of the recipient's face sheet to the PMP. Fax numbers for all PMPs may be found in the "About Medicaid" section on the Medicaid website: www.medicaid.state.al.us.

Ancillary services provided during the RTF stay may be billed fee-for-service if the recipient has been granted an exemption from the Patient 1st Program.

Written requests for Patient 1st exemptions should be submitted to Medicaid by the recipient's case worker or the RTF at the time of admission to the residential facility.

Requests must be submitted on the Patient 1st Medical Exemption Request found on the Medicaid website: www.medicaid.state.al.us under the Patient 1st tab.

Written notification shall be provided to Medicaid by the caseworker or the RTF at the time of the recipient's discharge or transfer to another facility.

All correspondence regarding Patient 1st should be mailed to:

Alabama Medicaid Agency
Attention: Patient 1st Program
P.O. Box 5624
Montgomery, AL 36103-5624

33.1 Enrollment

EDS enrolls psychiatric hospital providers and issues provider contracts to applicants meeting the licensure and certification requirements of the State of Alabama, the Code of Federal Regulations, the *Medicaid Administrative Code*, and the *Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a psychiatric hospital or RTF is issued an eight-character Medicaid provider number that enables the provider to submit claims and receive reimbursements for psychiatric hospital-related services All eight characters are required when filing a claim.

Psychiatric hospitals and RTFs are assigned a provider type of 05 (Hospital). The valid specialty for psychiatric hospitals is (W3) and (WF) for RTFs.

Enrollment Policy for Psychiatric Hospital Providers

To participate in the Alabama Medicaid Program, psychiatric hospital providers must meet the following conditions:

- Receive certification for participation in the Medicare program
- Possess a license as an Alabama psychiatric hospital in accordance with current rules contained in the Alabama Administrative Code. State hospitals that do not require licensing as per state law are exempt from this provision.

- Be accredited by the Joint Commission on Accreditation of Healthcare Organizations
- Have a distinct unit for children and adolescents
- Have a separate treatment program for children and adolescents
- Submit a written description of an acceptable utilization review plan currently in effect
- Submit a budget of cost for medical inpatient services for its initial cost reporting period, if a new provider

Psychiatric hospitals are required to submit a monthly inpatient census report to Medicaid. The census report must list the names of all Medicaid children and adolescents who are admitted to and discharged from the hospital during the calendar month. This report should also list the names of the children and adolescents who remain in the hospital during the calendar month. Medicaid must receive the report by the 10th of the following month. Failure to send the required report within the specified time period will result in the hospital's reimbursement checks being withheld, until the report is received by Medicaid.

Enrollment Policy for Residential Treatment Facilities (RTFs)

To participate in the Alabama Medicaid program, RTFs must meet the following conditions:

- Be accredited by JCAHO, CARF, COA, or be certified as an Alabama RTF in accordance with standards promulgated by the Alabama Department of Human Resources (DHR), the Department of Mental Health/Mental Retardation (DMH/MR), or the Department of Youth Services (DYS), or the Department of Children's Services (DCA).
- Be in compliance with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975
- Execute a contract or placement agreement with DHR, DMH/MR, DYS, or DCA to provide residential psychiatric treatment services in the State of Alabama
- Execute a provider agreement with Alabama Medicaid to participate in the Medicaid program;
- Submit a written description of an acceptable UR plan currently in effect
- Submit a written attestation of compliance with the requirements of 42 CFR, Part 483, Subpart G, regarding the reporting of serious occurrences and the use of restraint and seclusion
- Be in compliance with staffing and medical record requirements necessary to carry out a program of active treatment for individuals under age 21

All correspondence regarding application by Alabama RTFs for participation in the Medicaid program should be mailed to:

Alabama Medicaid Agency
Attention: Institutional Services
Box 5624
Montgomery, AL 36103.

33.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

For purposes of this chapter, an inpatient is a person admitted to a psychiatric facility for bed occupancy for purposes of receiving inpatient or residential psychiatric services.

The number of days of care charged to a recipient for inpatient psychiatric services is always a unit of a full day. A day begins at midnight and ends 24 hours later. The midnight to midnight method is used to report days of care for the recipients, even if the facility uses a different definition of day for statistical or other purposes.

Medicaid covers the day of admission, but not the day of discharge.

33.2.1 Therapeutic Visits

Therapeutic visits away from the psychiatric hospital to home, relatives, or friends are authorized if certified by the attending physician as medically necessary in the treatment of the recipient. Therapeutic visits are subject to the following limitations:

- No more than three days in duration
- No more than two visits per 60 calendar days per admission, per recipient

Therapeutic visit records will be reviewed retrospectively by Medicaid. Medicaid will recoup payments from providers who receive payments for therapeutic visits in excess of the amount as described above. This policy applies only to visits away from the psychiatric hospital. Visits away from the RTF are not limited by this policy.

33.3 Certification of Need for Inpatient and Residential Services

Providers should refer to Chapter 41 of the Medicaid Administrative Code for complete instructions on documenting the certification of need for inpatient or residential treatment services. Providers will find instructions for requesting prior authorization for inpatient hospital admissions and continued stays. Instructions for documenting emergency and non-emergency admissions to RTFs will also be found in Chapter 41.

All entries in the medical record must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must authenticate

his or her entry. Authentication may include signatures, written initials, or computer entry.

Reimbursement

Medicaid pays for inpatient services provided by psychiatric hospitals according to the per diem rate established for the hospital. The per diem rate is based on the Medicaid cost report and the provisions documented in the *Medicaid Administrative Code,* Chapter 23.

Providers are required to file a complete uniform Medicaid cost report for each fiscal year. Medicaid must receive one copy of this report within three months after the Medicaid year-end cost report.

Hospitals that terminate participation in the Medicaid program must provide a final cost report within 120 days of the date of termination of participation.

If a uniform cost report is not filed by the due date, the hospital shall be charged a penalty of $100.00 per day for each calendar day after the due date.

Medicaid pays for residential treatment services provided by RTFs according to the per diem rate established in the placement agreement between the RTF and the contracting state agency (DHR, DYS, DMH, DCA).

33.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by inpatient psychiatric hospitals or RTFs.

33.5 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Psychiatric hospitals and RTFs billing Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-92 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

33.5.1 Time Limit for Filing Claims

Medicaid requires all claims to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

33.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field. Only the diagnosis codes within the range of 290-316 are covered for services under this program.

33.5.3 Revenue Codes

Refer to the Alabama UB-92 Manual, published by the Alabama Hospital Association, for a complete list of revenue codes.

33.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-92 claim form.

33.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with Third Party Denials.

NOTE:

When an attachment is required, a hard copy UB-92 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

33.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-92 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N